STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155705	A. BUILDING 01 B. WING	05/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE POINTE	801 N HUNTINGTON AVENUE WARREN, IN46792

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/19/11 Facility Number: 000542 Provider Number: 155705 AIM Number: 100267380 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Heritage Pointe was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies, Life Safety Code (LSC) 18 New Health Care Occupancies in the Anthony and Greedy Wings, and 410 IAC 16.2.	K0000	Please note that in the Initial Comments section on Page 1 of Form CMS-2567, our Facility Number is shown as 000459. Our actual Facility Number is 000542.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	This three story facility was determined to be of Type I (332) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and resident rooms. The facility has a capacity of 186 and had a census of 131 at the time of this survey. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 combustible storage rooms in 2 B,	K0029	In order to identify other residents who may be affected, all storage areas were inspected to ensure any storage room measuring over 50 square feet in size is provided with a	06/08/2011

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	measuring over 50 square feet in size, was provided with a self closing device. This deficient practice could affect any of the 25 residents in 2 B. Findings include: Based on observation with the Director of Maintenance on 05/19/11 at 12:25 p.m., the corridor door to the 2 B storage room, measuring over 50 square feet in area containing cardboard boxes and furniture, lacked a self closing device. This was confirmed by the Director of Maintenance at the time of observation. 3.1-19(b)		self-closing device. All maintenance staff and the environmental supervisor have been in-serviced on the requirement that storage rooms measuring over 50 square feet are provided with a self-closing device. A self-closing device has been ordered for the storage area located on 2B. Expected delivery is June 3, 2011 and will be installed upon receipt. The maintenance supervisor will monitor storage areas within the facility to ensure that all doors in storage rooms measuring over 50 square feet have self-closing devices. Any problems or concerns will be reported to the QA Committee for review and recommendations.	
K0044 SS=E	Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 3 fire door sets on 2 B was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in	K0044	All fire doors were inspected to ensure they close and latch when released in order to identify other residents who may have the potential to be affected. All facility staff have been in-serviced on the requirement for positive latching on all automatic fire doors. A new door frame has been ordered	06/22/2011

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	accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect any of the 25 residents on the 2 B hall and any resident at the 2 B nurses' station. Findings include: Based on observation with the Director of Maintenance on 05/19/11 at 12:20 p.m., the right side fire door (when entering the 2 B hall from the 2 B nurses' station) failed to latch into the frame. Based on an interview with the Director of Maintenance at the time of observation, these doors were confirmed to be fire doors. 3.1-19(b)		to replace the bent door frame on 2B. Expected delivery is scheduled for June 20, 2011 and the new frame will be installed and inspected to ensure positive latching is achieved. All fire doors will be inspected monthly by maintenance staff to ensure positive latching is achieved. Any problems or concerns will be immediately directed to the maintenance supervisor and reviewed by the QA Committee for further recommendations.	
K0046 SS=C	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency light	K0046	All battery powered emergency lighting systems were tested for a minimum of 30 seconds to ensure	06/02/2011

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	fixtures of at least 1½ hour duration was tested monthly and annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on an observation with the Director of Maintenance on 05/19/11 at 11:15 a.m., a battery operated emergency task light was observed at the emergency generator. Based on an interview with the Director of Maintenance at the time of observation, there		they are working properly. All maintenance staff have been in-serviced on the Life Safety requirement that written documentation must be kept by the facility monthly as well as the annual test regarding battery powered emergency lighting. A documentation form has been developed to ensure written records of visual inspections and tests are kept by the facility for inspection regarding battery powered emergency lighting. QA monitoring will be performed monthly to ensure the required testing is completed and documented. Any questions or concerns will be reviewed by the QA Committee for recommendations.	

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	were no written records of a monthly or an annual test regarding the battery operated emergency task light available for review. 3.1-19(b)			
K0061 SS=F	Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 Based on observation and interview, the facility failed to ensure 1 of 1 manual water shut off valves for the health care facility was electronically supervisor. This deficient practice affects all occupants. Findings include: Based on observation with the Director of Maintenance on 05/19/11 at 11:50 a.m., the water shut off valve in the B-basement	K0061	All manual water shutoff valves in the facility were inspected to ensure they are electronically supervised. All maintenance staff have been in-serviced on the Life Safety Code Standard that all automatic sprinkler systems have valves supervised so that a local alarm will sound when valves are closed. Siemens has been contacted and the tamper switch in the B-basement is scheduled to be connected on June 7, 2011. QA monitoring of tamper switches	06/08/2011

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	mechanical room was secured in the open position with plastic tie straps. Wiring was observed at the shut off valve but was not connected. This was confirmed by the Director of Maintenance at the time of observation. 3.1-19(b)		will be performed quarterly by Korsens Fire Protection Service. Any problems or concerns will be reported immediately to the maintenance supervisor and reviewed by the QA Committee for further recommendations.	
K0064 SS=E	Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 1. Based on observation and interview, the facility failed to inspect 1 of 1 K-class fire extinguishers in the kitchen and 1 of 1 fire extinguishers in the health care generator room each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying it is in its	K0064	#1All fire extinguishers have been checked for proper inspection throughout the facility to ensure no other residents were affected. In-servicing has been provided to all maintenance staff regarding inspection requirements of fire extinguishers in all areas of the facility. The master fire extinguisher list has been checked and revised to ensure inclusion of all fire extinguishers on the monthly inspection documentation form. QA monitoring will be performed monthly to ensure all extinguishers have been inspected. Lack of documentation will be promptly reported to the maintenance supervisor for correction and reported to the QA Committee. #2All fire extinguishers throughout the building have been checked to ensure they are easily accessible	06/02/2011

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	designated place, it has not been actuated or tampered with and there is no obvious physical damage or condition to prevent its operation. This deficient practice could affect any number of kitchen staff and all occupants if there should be a fire at the health care generator. Findings include: Based on observations with the Director of Maintenance on 05/19/11 from 1:22 p.m. to 1:45 p.m., the monthly inspection tag on the following fire extinguishers lacked documentation of a monthly inspection since October 2010: a) the K-class fire extinguisher in the kitchen b) the fire extinguisher in the health care generator room This was acknowledged by the Director of Maintenance at the time of observations. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 Palliative Care unit		and immediately available in the event of a fire. In-servicing was provided to all maintenance staff regarding the Life Safety Code Standard to have all fire extinguishers easily accessible. During the in-service it was also noted that special attention should be observed during renovations and remodeling projects to ensure the standard is met. The fire extinguisher on the Palliative Care Wing was relocated on May 26, 2011 so that it is not blocked by doors leading into the Unit and is easily accessible and available in the event of a fire. QA monitoring will be performed monthly to ensure all fire extinguishers are easily accessible in the event of a fire. Any problems or concerns regarding fire extinguishers will be immediately reported to the maintenance supervisor and reviewed by the QA Committee.	

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	fire extinguishers was readily accessible at all times. NFPA 10, Standard for Portable Fire Extinguishers, Section 1-6.3 requires fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. This deficient practice could affect all 3 residents in the Palliative Care unit. Findings include: Based on observation with the Director of Maintenance on 05/19/11 at 12:56 p.m., access to the Palliative Care unit fire extinguisher was obstructed by one of the separation doors leading into the unit. This was acknowledged by the Director of Maintenance at the time of observation. 3.1-19(b)			